EXHIBIT "A"

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DEPT OF COURT RECORDS
CIVIL DIVISION

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA
CIVIL DIVISION

COVER SHEET

Plaintiff(s) ESTATE OF SHERWOOD Neil Hawk, ERIN HAWK Boger, Administratrix and individual	Case Number : GD-16-18533
	Type of pleading : Complaint in Civil Action
	Code and Classification :
	Filed on behalf of ERIN Hawk Boger, md. ERIN Hawk Boger. administratrix of ESTATE of SHERWOOD Neil Hawk (Name of the filing party)
Vs Defendant(s) VAPHS VA Pittsburgh Healthcare System VA Pittsburgh Medical Center (OAKLAND)	☐ Counsel of Record ☒ Individual, If Pro Se
	Name, Address and Telephone Number : ERIN Hawk Boger 613 East Penn Street New Bethlehem PA 16242 814-229-2587
	Attorney's State ID : N/A
	Attorney's Firm ID : N/A

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IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

CIVIL NO:

Estate of Sherwood Neil Hawk,
ERIN HAWK BOYER, individually
and administratrix

Plaintiff,

vs.

VA PHS
VA Pittsburgh Healthcare System
VA Pittsburgh Medical Center (Oakland)
University Drive
Pittsburgh PA 15240

Defendants,

NOTICE

YOU HAVE BEEN SUED IN COURT. IF YOU WISH TO DEFEND AGAINST THE CLAIMS SET FORTH IN THE FOLLOWING PAGES, YOU MUST TAKE ACTION WITHIN TWENTY (20) DAYS AFTER THIS COMPLAINT AND NOTICE ARE SERVED BY ENTERING A WRITTEN APPEARANCE PERSONALLY OR BE ATTORNEY AND FILING IN WRITING WITH THE COURT YOUR DEFENSES OR OBJECTIONS TO THE CLAIM SET FORTH AGAINST YOU. YOU ARE WARNED THAT, IF YOU FAIL TO DO SO, THE CASE MAY PROCEED WITHOUT YOU AND A JUDGMENT MAY BE ENTERED AGAINST YOU BY THE COURT WITHOUT FURTHER NOTICE FOR ANY MONEY CLAIMED IN THE COMPLAINT OR FOR ANY OTHER CLAIM OR RELIEF REQUESTED BY THE PLAINTIFF. YOU MAY LOST MONEY OR PROPERTY OR OTHER RIGHTS IMPORTANT TO YOU.

**YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE.
IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE,
GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO
FIND OUT WHERE YOU CAN GET LEGAL HELP.**

**ALLEGHENY COUNTY PUBLIC DEFENDER
542 FORBES AVENUE
PITTSBURGH PA 15215
412-350-2400**

IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY, PENNSYLVANIA

CIVIL NO:

Estate of Sherwood Neil Hawk,
ERIN HAWK BOYER, indiviaually
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Plaintiff,

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VAPHS
VA Pittsburgh Healthcare System
VA Pittsburgh Medical Center (Oakland)
University Drive
Pittsburgh PA 15240

Defendants,

COMPLAINT IN CIVIL ACTION

AND NOW comes the plaintiff and presents the following as her Complaint in the above captioned action.

PARTIES

1. The plaintiff is an individual who resides at 613 East Penn Street, New Bethlehem, Pennsylvania, 16242, phone 814-229-2587

2. Defendant VAPHS, or VA Pittsburgh Healthcare System is a legal entity whose address is University Drive, Pittsburgh PA 15240, phone 412-822-2222

OPERATIVE FACTS

3. On or about September 3, 2014, Sherwood Hawk was admitted to VAPHS, Oakland for a very common, minor matter called laproscopic LAR, to have polyps removed from his colon, which were discovered in a colonoscopy.

4. Shortly thereafter, the family was told that the operation had gone well, with no complications nor any reason to believe he would not return home in several days.

5. On September 5, 2014 or early on September 6, still under sedation and apparent surveillance, Sherwood aspirated. This was not noticed, recognized or dealt with by any of the professional staff at VAPHS.

6. At this time no family member was notified of this event, although staff members were shocked that no one had been contacted as this a sever matter, called "CODED" by the healthcare profession

7. Erin, the plaintiff herein, and Sherwood's daughter and only heir, consistently attempted to contact her father, with no success. Her (and Sherwood) live approximately 2 hours from the VAPHS, and she repeatedly called his room, thinking all was well, only to have a stranger answer who was apparently now in the room Sherwood had been in.

11. On or about September 12, the medical staff at VAPHS did admit that the surgery had, in fact, not gone well, as had been communicated to the family The aspiration was a direct result of the minor polyp removal not having been completed correctly by the persons involved in the procedure. His colon was not sewn shut, which should be a very basic skill and one that is done every day by competent medical professionals.

12. Thereafter, Sherwood was unable to function or communicate in any way. Complications arose from this negligence and incompetence, that required Sherwood to be totally and completely on life support for the next several weeks, during which time family members visited and called on an almost daily basis,

taking off work and necessary duties, hoping and praying that Sherwood would return to the health, vibrancy, duties, church, social and family life which he had so richly enjoyed, and had been so active in.

13. It was also discovered that Sherwood had become, by this hospital stay, become highly septic, which matter also could have been prevented by competent care and ability

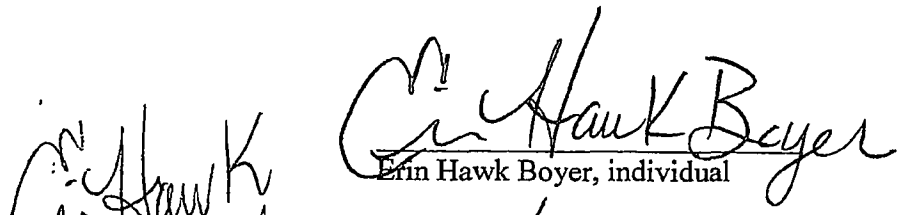
14. On September 25, 2014 Sherwood Neil Hawk died of Hypoxic Respiratory Failure and Aspiration Pneumonia. This was clearly caused by the inattention, negligence, and cover up of the persons involved in his care at VAPMS, who should have realized that the trauma, pain and suffering was completely preventable..

15. The family and friends have thus been thus deprived of Sherwood's skills, expertise, love, discipline, child care, facilities and machinery maintenance, joy, humor, concern and camaraderie, which would certainly have continued for many years had the circumstances have been dealt with in a competent manner by the medical professionals at VAPMS, Oakland.

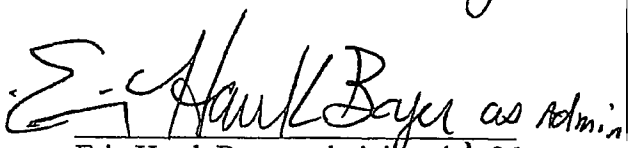
16. For the reasons listed above, backed up by the facts presented on Exhibit "A" attached hereto and to be made a part hereof, we are pleading for the untimely loss of this person to be compensated for monetarily. We realize that the value placed on the continued years we would have enjoyed with Sherwood are priceless, and realize that no monetary amount could possible compensate for his untimely and entirely preventable death, but believe that VAPHS does owe the Estate of Sherwood Neil Hawk, his family and associates, a sum that can in some small way attempt to compensate for the value that his continued life, vitality and service would have been a benefit to all for the many years he should have lived.

WHEREFORE, showing all these things, the plaintiff demands judgment against each of the above named defendants in an amount in excess of Four Hundred Thousand and No/100 ($400,000.00) dollars plus cost of suit.

Respectively submitted,



Erin Hawk Boyer, individual



Erin Hawk Boyer, administratix of the

Estate of Sherwood Neil Hawk

Exhibit A

Clinical Summary/Final Summary

The Veteran, a 66 year old Caucasian male, was admitted on 09/03/2014 for elective laparoscopic sigmoid colectomy given history of tubular adenoma with carcinoma in situ. He had no intraoperative complications and was extubated immediately postoperatively and transferred to floor on 09/04. His past medical history included an open radical prostatectomy with bilateral pelvic lymph node dissection (05/13/2010) for prostatic

[redacted]

Lab Results

adenocarcinoma complicated by urinary incontinence. The patient had a history significant for smoking (1.5 PPD, 55 years), [redacted] (33years, last intake prior to endoscopy on 09/02/2014), and COPD.

Postoperatively, he complained of abdominal pain, denied passing flatus or having bowel movements, and had occasional cough. On 09/05, he became very anxious, difficult to re-orient, intermittently confused, tachycardic and hypertensive, and was treated for [redacted] with benzodiazepines. Later, he had 2 episodes of bloody emesis and became hypoxic. He developed acute respiratory failure after a witnessed aspiration event and a condition C was initiated, and he was returned to ICU. He was intubated for refractory hypoxia and airway protection and was started on empiric piperacillin/tazobactam and bacterial cultures were sent.

The patient also developed hemodynamic instability (requiring pressors) and abdominal distension with fevers and leukocytosis. A CT scan was performed and demonstrated a large amount of fluid with free air within the pelvis as well as thickening of some loops of bowel concerning for anastomotic leak. On 09/12, he was taken back to the operating room for an exploratory laparotomy and was found to have findings consistent with a small defect in the posterior aspect of the anastomotic site. A washout and diverting loop ileostomy were performed and intra-abdominal drains were introduced. A CT scan performed on 09/17 showed persistent moderate bilateral pleural effusions with lower lobe atelectasis and consolidations with interval progression and trace amount of fluid with diffuse peritoneal fat stranding suggestive of peritonitis or post-infectious changes. There was also residual peritoneal fluid in the left abdomen. He had some delayed ostomy function and so was started on total parenteral nutrition. He continued to require ventilation and aggressive supportive care while developing mild acute kidney injury with a variable creatinine. His respiratory status improved enough for extubation on 09/24/2014 but subsequently required re-intubation. The decision was made by the patient's next of kin to change the patient's code status to DNR and to initiate comfort measures only on 9/25 AM; per family request, terminal extubation and withdrawal of pressors were on 9/25pm. Patient expired shortly thereafter; time of death was 21:27 on 09/25/2014.

The suspected clinical cause of death is respiratory failure.

On autopsy, examination of the abdominal cavity demonstrated adherent bowel loops and a collection of thick tan-yellow exudate in the left lower quadrant. The bowel wall adjacent to this area showed patchy necrosis that in some regions extended transmurally. The lumen of the sigmoid colon contained a large multiloculated abscess cavity with tan-yellow gelatinous exudate. In this area there was transmural necrosis with prominent fat necrosis and scattered Gram negative rods, rare Gram positive cocci in pairs and short chains, and few fungal forms morphologically consistent with Candida spp. Aerobic culture was

Lab Results

positive for heavy Enterobacter cloacae, rare Klebsiella pneumoniae, heavy alpha-hemolytic Streptococcus (viridans group), and light presumptive Candida albicans. These findings are consistent with complications of an anastomotic leak with secondary inflammatory response. It is noteworthy that both endoscopic and operative notes describe severe diverticulosis, tortuosity and spasm in the sigmoid colon, which possibly contributed to the anastomosis non-healing/leak and colonic abscess formation. There was evidence of end-organ damage including hepatomegaly with ischemic parenchymal changes and significant splenic softening. These findings are consistent with the patient's history of hemodynamic instability and ventilation-dependent respiratory failure. The lungs showed bilateral emphysematous changes predominant in the upper lobes with moderate anthracosis, findings consistent with the patient's history of COPD. There was global alveolar collapse and interstitial fibrosis as well as organized consolidations of both lower lobes. In addition, the right lower lobe showed multifocal ill-formed necrotic granulomas, negative for fungi and mycobacteria, likely due to aspiration. Culture of lung tissue was negative for Legionella and other pathogens, and only grew very rare coagulase-negative Staphylococcus. The gastro-esophageal junction showed a superficial mucosal ulceration, consistent with nasogastric tube placement.

Examination of the cardiovascular system showed mild hypertrophy of the interventricular septum and left ventricle. In addition, the left ventricle showed some perivascular myxoid change. No definite evidence of recent or prior ischemic event was seen. The right coronary and left anterior descending arteries showed changes of calcific atherosclerotic disease with 15% and 50 % luminal occlusion, respectively. The abdominal aorta showed moderate calcific atherosclerosis, most prominent in the area of the bifurcation. The kidneys showed granular cortical surfaces with numerous simple cortical cysts. Microscopically, medial thickening of both small and larger vessels was seen. These changes are consistent with changes of hypertensive and atherosclerotic cardiovascular disease. Evidence of the patient's prior prostatectomy was confirmed, with a small amount of residual seminiferous tubule seen on the right side.

GROSS DESCRIPTION

The body is that of a well-developed, well-nourished 66 year old Caucasian man who appears compatible with the reported age. Patient identification band is around the left wrist. The body is cool (refrigerated). Rigor mortis is set. Purple livor mortis extends over the posterior surfaces of the body, except in areas exposed to pressure. The scalp hair is grey-black in a medium length. The irides are blue. The corneae are translucent. The sclerae are white and the conjunctivae are clear. No petechial hemorrhages are identified on the sclerae, bulbar conjunctivae, facial skin or oral mucosa. The nose and ears are normally formed. The teeth are intact and in fair condition. The neck is unremarkable. The thorax is well developed and symmetrical. The abdomen is flat. The spine is normally formed and the surface of the back is

Lab Results

free of lesions. The external genitalia are those of a normal adult male. There is scrotal edema. The upper and lower extremities are well developed with mild edema, without absence of digits. The right and left great toes show purple discoloration.

Evidence of medical intervention includes:
- circular bandage, sacral area
- puncture marks, right antecubital area and right wrist
- IV catheter, left antecubital area
- Midline abdominal wound, 23 cm: packed with gauze, clean and dry
- Diagonal staple line, 1.7 cm, left upper abdomen: intact
- Diagonal staple line, 8 cm, left lower abdomen: intact
- Stoma site, right lower abdomen: erythematous, with tan opaque exudate
- 3 drains, abdominal cavity, one left and two lower right
- Foley catheter: with 50 mL dark yellow urine in the collection container

INTERNAL EXAMINATION

BODY CAVITIES: There are bilateral pleural adhesions. All body organs are in normal and anatomic position.

CARDIOVASCULAR SYSTEM: The heart weighs 410 grams. The pericardial sac is free of significant fluid or adhesions. The pericardial surfaces are smooth and glistening. The coronary arteries arise normally and follow the distribution of a right dominant pattern. The mid to distal right coronary artery shows mild atherosclerotic disease with up to 25% luminal occlusion. The mid left anterior descending artery shows moderate atherosclerotic disease with up to 50% luminal occlusion. The interventricular septum and left ventricular wall show mild hypertrophy (1.3 and 1.2 cm, respectively). The right ventricle thickness is 0.5 cm. The valves are proportionate (tricuspid 12.5 cm, pulmonic 9.0 cm, mitral 10.5 cm and aortic 8.5 cm). The foramen ovale is closed. The valves are normally formed, thin and pliable, and free of vegetations and degenerative changes. The myocardium is dark red brown, firm, and free of focal or regional fibrosis, erythema, pallor or softening. The atrial and ventricular septa are intact and the septum and free walls are free of muscular bulges. The aorta and its major branches arise normally and follow the usual course, with moderate calcific atherosclerotic change in the area of the bifurcation. The orifices of the major aortic vascular branches are patent. The vena cava and its major tributaries are patent and return to the heart in the usual distribution and are unremarkable.

RESPIRATORY SYSTEM: The right and left lungs weigh 1090 and 980 grams, respectively. The upper and lower airways are patent; the mucosal surfaces are smooth and yellow tan. The pleural surfaces are nodular and congested. The pulmonary parenchyma is variegated pink to dark red purple with moderate anthracosis and the cut surfaces exude moderate amounts of blood and frothy fluid. Both lower lobes are densely consolidated with several small tan-yellow irregular necrotic foci (up to 1 cm) seen on the

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[New Case Number] [Sheriff Service History] [Notification History] [Docket Report] [Account Information] [Home]

GD-16-018533 Boyer vs VA Pittsburgh Health Care System etal

Filing Date:	**09/30/2016**	*Case Type:*	**Medical/Hospital Liability**
Filing Time:		*Court Type:*	**General Docket**
Related Cases:	--	*Current Status:*	**Sheriff Return**
Judge:	**No Judge**	*Jury Requested:*	**No**
Amount In Dispute:	**$ 400000.00**		

***Click on PartyID hyperlink to see Alternative name for the party.**

Parties

-- Litigants --

ID	LName	FName	MI	Type	Address	Initial Service Completion	Attorney
@2252116	Boyer	Erin	H.	Plaintiff	No Default Address Available	--	Pro Se,
@1166094	VA Pittsburgh Health Care System	---	---	Defendant	No Default Address Available	10/20/2016 16:00	--
@2252118	VA Pittsburgh Medical Center	---	---	Defendant	University Drive Pittsburgh PA 15220	--	--
@2252117	VAPHS	---	---	Defendant	University Drive Pittsburgh PA 15240	--	--

-- Attorney --

ID	LName	FName	MI	Type	Address	Phone
PROSE	Pro Se	---	---	Plaintiff's Attorney	No Default Address Available	--

-- Non Litigants --

No Listing

***Click on DocketType hyperlink to see Judgments for that Docket.**
Document numbers in the DOCUMENT column may not be consecutive.

Docket Entries

Filing Date	Docket Type	Docket Text	Filing Party	Document
10/20/2016	Sheriff Return	VA Pittsburgh Health Care System was served by Served - Adult Agent or person in charge of Defendant(s) office or	Boyer Erin H.	Sheriff Return

		usual place of business Service Upon Babara Forsha with Complaint on 10/20/2016.		
09/30/2016	Complaint	Returnable 10/30/16	Boyer Erin H.	Document 1

Services Complete Service History

Desc	Name	Service Address	Person Served	Served By	Service Date	Service Time	Status
Complaint	VA Pittsburgh Health Care System	000 Univeristy Drive Pittsburgh, PA 15240 Pittsburgh/4	Babara Forsha	Neil Hall	10/20/2016	16:00	Served - Adult Agent or person in charge of Defendant (s) office or usual place of business

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